

# Biblical Seminary of the Philippines

P.O. Box 11      Valenzuela      Metro Manila      Philippines

## HEALTH RECORD AND EXAMINATION

### Health Record

To be filled out by Student

[ ] Single      Social Security No. \_\_\_\_\_  
[ ] Married      Date (present) \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Birthplace \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

FAMILY HISTORY	Name	Alive	Present State of Health	Deceased	Cause of Death
Father's name _____					
Mother's name _____					
Brothers (number) _____					
Sisters (number) _____					
Husband's/Wife's name _____					
Children (number) _____					

#### Additional Information:

Have any members of your family or blood relatives ever had: (name relationship)

Tuberculosis \_\_\_\_\_ Heart disease \_\_\_\_\_

Mental Disturbance \_\_\_\_\_ Kidney disease \_\_\_\_\_

Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_

Any chronic diseases not mentioned \_\_\_\_\_

### PERSONAL

History of Injuries and/or Operations: (Give nature, year, and hospital)

\_\_\_\_\_

History of previous illness: (check and give year)

Rheumatic Fever \_\_\_\_\_ Mumps \_\_\_\_\_ Asthma \_\_\_\_\_

Appendicitis \_\_\_\_\_ Pneumonia \_\_\_\_\_ Malaria \_\_\_\_\_

Tuberculosis \_\_\_\_\_ Allergy \_\_\_\_\_ Epilepsy \_\_\_\_\_

Measles \_\_\_\_\_ Polio \_\_\_\_\_ Diabetes \_\_\_\_\_

Additional information of acute illness \_\_\_\_\_

Mental disturbance \_\_\_\_\_

Psychological counseling \_\_\_\_\_

### GENERAL APPEARANCE

Height \_\_\_\_\_ Weight usual \_\_\_\_\_ Weight present \_\_\_\_\_

Skin \_\_\_\_\_ Eyes \_\_\_\_\_ Vision \_\_\_\_\_ Wear glasses \_\_\_\_\_

Last refraction of eyes \_\_\_\_\_ Teeth \_\_\_\_\_ Need dental work? \_\_\_\_\_

Last visit to dentist \_\_\_\_\_

General Observations: Can you eat a normal, balanced diet? \_\_\_\_\_ If not, explain \_\_\_\_\_

In what sports do you regularly participate? \_\_\_\_\_

**Physical Examination**

To be completed by Doctor

Name of applicant \_\_\_\_\_ Date of examination \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_ Pulse rate \_\_\_\_\_

Normal	Check each item in appropriate column (enter NE if not evaluated)	Abnormal	Remarks
	1. Posture		
	2. Speech		
	3. Skin and lymphatics		
	4. Nose and sinuses		
	5. Ears and hearing		
	6. Mouth, throat and tonsils		
	7. Teeth, breath, and gums		
	8. Eyes		
	9. Heart		
	10. Lungs and chest		
	11. Abdomen (include hernia)		
	12. Back, spine and joints		
	13. Geneto-urinary system		
	14. Endocrine system		
	15. Nutrition		
	16. Nervous system		
	17. Menstrual cycle		
	18. Past drug use (indicate nature)		
	19. Emotional problems		

Allergic to any Drugs \_\_\_\_\_  
 Operations \_\_\_\_\_  
 Haemoglobin \_\_\_\_\_ Blood serology required \_\_\_\_\_  
 Urinalysis—positive findings \_\_\_\_\_  
 Immunization Record: Give dates \_\_\_\_\_  
 Typhoid \_\_\_\_\_ Polio \_\_\_\_\_ Diptheria \_\_\_\_\_ Tetanus \_\_\_\_\_  
 Chest X-ray within 1 year \_\_\_\_\_ Results \_\_\_\_\_  
 or Tuberculin Test within 1 year \_\_\_\_\_ Results \_\_\_\_\_  
 "Polio and Tetanus inoculation REQUIRED" \_\_\_\_\_

**SUMMARY**

In my opinion the applicant's physical condition is:  
 Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_  
 In my opinion the applicant's emotional stability is:  
 Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Not known \_\_\_\_\_

**Recommended:**

Signature of Physician \_\_\_\_\_ M. D.  
 Name of physician (type or print) \_\_\_\_\_  
 Address of physician \_\_\_\_\_